# Cognitive Deficits and Other Hidden Disabilities Among Homeless Men and Women

Prepared for
State of Virginia PATH Providers
Webinar Presentation

By Virginia Luchetti, EdD

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# Introduction

- Portions of this presentation have been previously presented at the following conferences:
  - GAINS Conference, Boston (April, 2006)
  - SAMHSA Treatment for Homeless Technical Assistance Conference, Baltimore (January, 2006)
  - National Homeless Technical Assistance Conference, Preparing People for Change, Knowledge and Choice, Washington, DC (October, 2005)
  - Housing California, Creating Community, Pasadena, California (December 2005)
  - National Association of State Head Injury Administrators 17th Annual Meeting, Baltimore, Maryland (September 7, 2006)
  - Healthcare for the Homeless Conference, Washington, DC, June, 2007
  - National Alliance to End Homelessness Conference, Washington, DC, July 2007

# Funding

Project HOPE (Homeless Outreach Project to Encampments) was funded by SAMHSA and HRSA partially under the Chronic Homeless Initiative sponsored by the United States Interagency Council on Homelessness.

# What do we want to accomplish today?

1. Reinforce what we know about cognitive impairment and developmental disabilities
2. Increase our understanding about the differences between cognitive impairment, developmental disabilities and other disorders
3. Increase our effectiveness in documenting impairment and treating disabled clients

# For reference articles, please email

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# Cognitive Impairment in Homeless Men and Women

Review of research

# More Questions than Answers

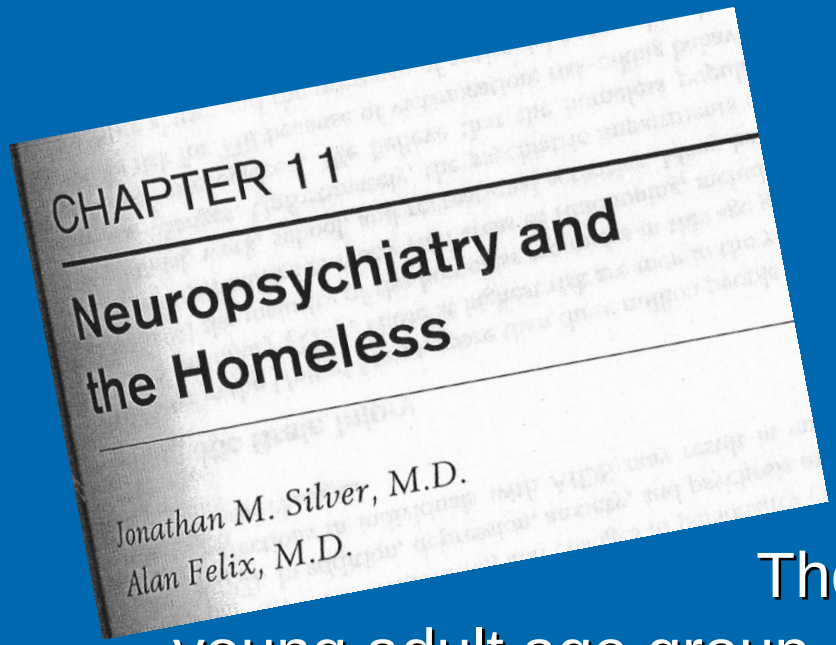
- Is there a greater incidence of cognitive impairment among homeless men and women?
- Does homelessness increase the risk of cognitive impairment?
- Why is there so little attention to this issue?
- Do the residual effects of cognitive impairment make it more difficult for someone to exit homelessness?


"Many studies [of the 18] reviewed have recorded high rates of depression, schizophrenia, alcohol dependence and head injury among the homeless."

# Rio de Janeiro
# A study of 330 shelter dwellers

"The main findings concern prevalence rate of major mental illness, which was 19.4% for the 12 months before data collection, and 22.6% lifetime prevalence rate. Other 12-month prevalence rates were 31% for alcohol abuse/dependence, 4.1% for drug abuse/addiction, 15% for severe cognitive impairment, and 49.2% for any mental disorder. The rate was 65.2% when organic mental disorders were added."

Mental illness in an adult sample admitted to public hostels in the Rio de Janeiro metropolitan area, Brazil. Author(s): Lovisi GM; Mann AH; Coutinho E; Morgado AF Social Psychiatry And Psychiatric Epidemiology 2003 Sep; Vol. 38 (9), pp. 493-8.


CHAPTER 11

Neuropsychiatry and the Homeless

Jonathan M. Silver, M.D.
Alan Felix, M.D.

"Each year in the United States, more than three million people sustain a traumatic brain injury. Those at highest risk are men in the young adult age group, and the majority of the homeless are males in this age group. . . . Unfortunately, the psychiatric impairments caused by TBI often go unrecognized. We believe that the homeless population is at increased risk for TBI because of victimization; risk-taking behaviors, including substance abuse; and the presence of antisocial personality disorder." p. 321 (1999)

# Wisconsin

"This study explored the neuropsychological functioning of 90 homeless men. There was great variability in their test scores, but the presence of possible cognitive impairment was detected in 80% of the sample."

Neuropsychological functioning of homeless men. Author(s): Solliday-McRoy C; Campbell TC; Melchert TP; Young TJ; Cisler RA: The Journal Of Nervous And Mental Disease 2004 Jul; Vol. 192 (7), pp. 471-8.

British Journal of Psychiatry (1996), 169, 434–439

Cognitive Function and Duration of Rootlessness in Entrants to a Hostel for Homeless Men

ALEXANDER J. BREMNER, PETER J. DUKE, HAZEL E. NELSON, CHRISTOS PANTELIS and THOMAS R. E. BARNES

"A consecutive series of 80 roofless entrants to a hostel for homeless men were sampled, and 62 completed a range of assessments. . . "

"Forty-six per cent of the sample had a history of head injury sufficient to lose consciousness at some time in their life. In some cases, personality changes following head injury appeared to have contributed to the subjects becoming roofless."

# Glasgow

"From a sample of 266 hostel dwellers, 82% had cognitive impairment and 78% were drinking hazardously. The prevalence of ARBD (Alcohol Related Brain Damage) among homeless hostel dwellers was 21%. Conclusions: ARBD has a high prevalence among homeless hostel dwellers and treatment is usually effective. There is a need to actively identify and treat this population to help them move out of homelessness."

Prevalence of alcohol related brain damage among homeless hostel dwellers in Glasgow. Authors: Gilchrist, Gail Morrison, David S., European Journal of Public Health; Dec 2005, Vol. 15 Issue 6, p 587-588

Original Research

# Old and Homeless: A Review and Survey of Older Adults Who Use Shelters in an Urban Setting

Vicky Stergiopoulos, MSc, MD, FRCPC[1], Nathan Herrmann, MD, FRCPC[2]

A review of 157 case files of people in Chicago who were referred for emergency-shelter service revealed that 45% of the women and 31% of the men displayed confusion, disorientation, or paranoia (7). Similarly, 43% of the men in New York living on skid row reported memory difficulties, with 9% classified as having mild-to-moderate dementia and 5% classified as having moderate-to-severe dementia (6). In London, 55%

# Previous Research

- 1965 Kean concluded that homeless men have problems with memory, attention, and perception
- 1970 Skid Row study of 200 men -- 36% were found to have chronic organic brain syndrome
  - Goldfarb
- 1975 Salvation Army Men's Service Center – 37 homeless men – 50% had some form of brain damage
  - Fittante
- 1988 Los Angeles – 379 Skid Row Inhabitants. 1.8% showed severe cognitive impairment with no evidence of serious mental illness or substance dependence.
  - Koegel, Burnam & Farr


freeGAS

# Previous Research

- 1990 New Orleans – 30 homeless male veterans were found to be "superior on measures of cognitive efficiency, problem solving, common-sense reasoning, and observation of detail."
  - Foulks, McCown, Duckworth, & Sutker, 1990
- 1993 Sydney, Australia – 65 homeless men living in shelter. 18 had severe cognitive impairment, 10 had mild impairment
  - Teesson & Buhrich
- 1996 Edinburgh – 136 homeless people. "One of the most striking findings in this survey was the high prevalence of cognitive impairment."
  - Geddes, Newton, Bailey, Freeman, Young

# Previous Research

- 1996 London – 60 hostel residents. "Estimated premorbid IQ, current IQ, and cognitive speed were significantly lower than the norm."
  - Bremner, Duke, Nelson & Pantelis, & Barnes
- 1997 Orange County, California – 24 homeless individuals. WAIS-R showed full scale IQ lower than average. 50% had attention problems, 33% had memory problems, 24 had history of head injury.
  - Cotman & Sandman
- 1998 Miami -- 33 homeless individuals. "Substantial subset . . . suffer from 'occult' neurological deficits"
  - Douyon, Guzman, Romain, Ireland, Mendoza, Lopez-Blanco & Milanes

# Previous Research

- 2000 Sydney, Australia -- 204 homeless men and women assessed with MMSE. 10% showed cognitive impairment.
  - Buhrich, Hodder & Teesson, 2000
- 2001 Miami – 60 homeless individuals. 80% showed “impaired test battery performance” and 35% showed impaired MMSE
  - Gonzalez, Dieter, Natale & Tanner, 2001
- 2004 Wisconsin -- 90 homeless men -- 80% found to have possible cognitive impairment
  - Solliday-McRoy, Campbell, Melchert, Young, & Cisler

# TBI Research Review

TBI Research Review ➧ Policy & Practice
2006: No.

# matic Brain Injury

The aim of TBI Research Review is to summarize current research on traumat brain injury (TBI), offer suggestions for future research planning and suggest application of research findings to clinical practice and policy. The focus in th second issue is on UNIDENTIFIED TBI.

Millions of people have experienced a traumatic brain injury (TBI), but they are unaware that TBI is the underlying cause of problems they subsequently experience, such as poor memory, difficulties in learning and behavioral changes. These individuals had a blow to the head, were dazed and confused, perhaps even lost consciousness, perhaps got medical attention and then went on with their lives. They thought once the headaches or dizziness went away all would be fine, but they didn't notice that all was *not* right. Or, they did notice but didn't identify the source of their problems as the brain injury. The result is that they have substantial, persisting cognitive, behavioral and social difficulties - seemingly out of the blue - with no explanation

problems. Tim is a person with "hidden TBI", in the sense that he has daily challenges associated with a brain injury but is unaware of their cause.

- In contrast, because **John** was hospitalized with a TBI two years ago, he *was* educated about the probable consequences of brain injury. Because of this awareness, when he visits his psychologist for treatment of clinical depression, she knows to carefully adapt her methods to accommodate John's substantial post-TBI memory problems. For example, she repeats certain exercises several times so that he is able to learn the ideas and apply them in daily life. Also, because of her knowledge of TBI, she realize that a referral to a job coach may be neede

# Cognitive Impairment in Homeless Men and Women

Implications and importance

Why do some people manage to live in houses and work while other people become homeless?

The National Coalition for the Homeless (2004) has estimated that 760,000 people are homeless on any given day in this country, and approximately 2 million people have been unsheltered for a period of time in the past year.

Survival Analyses of Social Support and Trauma Among Homeless Male and Female Veterans Who Abuse Substances Author(s): Benda, Brent B., University of Arkansas at Little Rock Source: American Journal of Orthopsychiatry, Vol. 76(1), January 2006. pp. 70-79.

# Homeless Treatment 2008

# A Vision of Future Homeless Treatment


MOTO
10-13-3
STEEL RESERVE

# The overlooked and often disguised disorders

- Disabling Cognitive Impairment
- Posttraumatic Stress Disorder
- Developmental Disabilities
- Attention-Deficit Hyperactivity Disorder
- Mild Mental Retardation

# Cognitive Impairment Includes

- Memory problems
- Problems learning new information
- Problems recalling previously learned information
- Problems with language, movement, or recognizing things
- Problems with planning, organizing and sequencing

From DSM-IV-TR, American Psychiatric Association criteria for Dementia

# Client: RD (male, age 56) cognitive profile

General Intellectual Ability — 43rd percentile

Grade equivalent: 8.4 — Age equivalent: 13

Verbal Ability — 86th percentile

Grade equivalent: >18 — Age equivalent: >25

Executive Processes — 39th percentile

Grade equivalent: 5.2 — Age equivalent: 10

Long-Term Retrieval — 22nd percentile

Grade equivalent: 1.0 — Age equivalent: 6

Fluid Reasoning — 36th percentile

Grade equivalent: 3.8 — Age equivalent: 9

# Client: FC (male, age 55)

General Intellectual Ability

12th percentile

Grade equivalent: 2.7

Age equivalent: 8

Verbal Ability

16th percentile

Grade equivalent: 5.9

Age equivalent: 11

Executive Processes

6th percentile

Grade equivalent: 1.8

Age equivalent: 7

Long-Term Retrieval

19th percentile

Grade equivalent: K.8

Age equivalent: 5

Fluid Reasoning

15th percentile

Grade equivalent: 1.8

Age equivalent: 7

# Client: CM (male, age 56)

General Intellectual Ability

Grade equivalent: 10.0 Age equivalent: 14

Verbal Ability

Grade equivalent: 17.5 Age equivalent: >25

Executive Processes

Grade equivalent: 10.1 Age equivalent: 15

Long-Term Retrieval

Grade equivalent: 1.1 Age equivalent: 6

Fluid Reasoning

77th percentile

Grade equivalent: 10.0 Age equivalent: 16

# Clinical Dilemma

- Cognitively impaired clients can appear very high functioning.  Many have high verbal skills.
- Alcohol use does not significantly affect verbal ability.
- It is virtually impossible to detect cognitive impairment without conducting a formal assessment.
- Clinical judgment is often not accurate when working with this population.

# An Overview of Brain Injury

# Traumatic Brain Injury

Reference Material

# Facts about Traumatic Brain Injury

## What is a traumatic brain injury?

A traumatic brain injury (TBI) is defined as a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. Not all blows or jolts to the head result in a TBI. The severity of such an injury may range from "mild," i.e., a brief change in mental status or consciousness to "severe," i.e., an extended period of unconsciousness or amnesia after the injury. A TBI can result in short or long-term problems with independent function.

## How many people have TBI?

Of the 1.4 million who sustain a TBI each year in the United States:

- 50,000 die;
- 235,000 are hospitalized; and
- 1.1 million are treated and released from an emergency department.[1]

Does homelessness put you at increased risk of head injury?

# Does head injury put you at increased risk of homelessness?

Have you ever had a head injury?

# “How many times have you been hit in the head?”

He stated he had been in “fights all my life” and then described being hit in the head with baseball bats, pipes, and hammers, mainly during his early teenage years.

# “How many times were you in a car accident?”

He reports that when he was 7 years of age, he was riding his bike. He states he was hit by a car and thrown twenty feet. He reports another bicycle accident when he was 11 years of age in which he was hit by a car. He states that the impact threw him over the hood of the car. He reports a car accident at age 15. He reports that his head forcefully impacted the car windshield breaking the glass. He states that his head went through the windshield. He reports being rear-ended at 22 years of age and stated that the force of the accident caused the windshield to break. Lastly in the winter of 2005 he was a passenger in a car that spun on black ice, rolled three times, and landed upside down in a creek.

# Homeless People Tend to be More at Risk of Injury

Upon necroscopic examination of a homeless male found comatose in the street and pronounced dead at a medical center 12 hours later, a sharp tip of a knife lodged in the right parietal region of his skull was incidentally discovered. Subsequent police investigation revealed that this was the remnant of a stabbing attempt on his life several months prior to his death.

Souvenir knife: a retained transcranial knife blade. Author(s): Davis NL; Kahana T; Hiss J Author's Address: National Center of Forensic Medicine, Tel Aviv, Israel. Source: The American Journal Of Forensic Medicine And Pathology: 2004 Sep; Vol. 25 (3), pp. 259-61.

# What is a traumatic brain injury?

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From the Brain Injury Association of America website

# *Who is at highest risk for TBI?*

- Males are about 1.5 times as likely as females to sustain a TBI.
- The two age groups at highest risk for TBI are 0 to 4 year olds and 15 to 19 year olds.
- Certain military duties (e.g., paratrooper) increase the risk of sustaining a TBI.
- African Americans have the highest death rate from TBI.

From the Brain Injury Association of America website

# *What causes TBI?*

- The leading causes of TBI are:
  - Falls (28%);
  - Motor vehicle-traffic crashes (20%);
  - Struck by/against (19%); and
  - Assaults (11%).
  - Blasts are a leading cause of TBI for active duty military personnel in war zones.

From the Brain Injury Association of America website

# *What are the long-term consequences of TBI?*

- The Centers for Disease Control and Prevention estimates that at least 5.3 million Americans currently have a long-term or lifelong need for help to perform activities of daily living as a result of a TBI.

From the Brain Injury Association of America website

# *What are the long-term consequences of TBI?*

- According to one study, about 40% of those hospitalized with a TBI had at least one unmet need for services one year after their injury. The most frequent unmet needs were:
  - Improving memory and problem solving;
  - Managing stress and emotional upsets;
  - Controlling one's temper; and
  - Improving one's job skills.

From the Brain Injury Association of America website

# *What are the long-term consequences of TBI?*

- TBI can cause a wide range of functional changes affecting thinking, sensation, language, and/or emotions. It can also cause epilepsy and increase the risk for conditions such as Alzheimer's disease, Parkinson's disease, and other brain disorders that become more prevalent with age.

From the Brain Injury Association of America website

# *Anoxic Brain Injury*

- Anoxic Brain Injury occurs when the brain does not receive any oxygen. Cells in the brain need oxygen to survive and function.
  Types of Anoxic Brain Injury
  - Anoxic Anoxia- Brain injury from no oxygen supplied to the brain
  - Anemic Anoxia- Brain injury from blood that does not carry enough oxygen
  - Toxic Anoxia- Brain injury from toxins or metabolites that block oxygen in the blood from being used

- Zasler, N. Brain Injury Source, Volume 3, Issue 3, Ask the Doctor

# Developmental Disability

# Developmental Disabilities

- Usually first diagnosed in infancy, childhood or adolescence
- Life-long disabilities
- Examples:
  - Autism
  - Epilepsy
  - Mental Retardation
  - Down Syndrome
  - Cerebral Palsy
  - Fetal Alcohol Spectrum Disorder

# Developmental Disabilities

- Refers to disabilities affecting daily functioning in three or more of the following areas:
  - capacity for independent living
  - economic self-sufficiency
  - learning
  - mobility
  - receptive and expressive language
  - self-care
  - self-direction

# Developmental Disability

- Does not communicate at age level
- Reasoning is more concrete than abstract
- Short attention span and memory
- Difficulty with simple tasks
- Immature social relationships
- Overly compliant
- Focus is on immediate or short-term consequences

# Communication

- Difficult understanding or answering questions
- Mimics responses or answers
- Limited vocabulary and grammar
- Takes a long time to answer
- Speech may be difficult to understand

# Reasoning

- Recognizes only literal interpretation of what is said or observed
- May not understand sarcasm, jokes, proverbs

# Short Attention Span

- Easily distracted
- Difficulty staying on task
- Forgets details
- Difficulty remembering instructions/tasks with more than two steps
- May get upset when routine is changed
- Poor use of unstructured time

# Relationships

- May not form friendships with other adults
- Easily frustrated
- Uses immature coping methods – withdraws, tantrum, assault
- Needs help to verbalize problems and explore options

# Overly Compliant

- Easily influenced by others
- Vulnerable to peer pressure
- Tries very hard to please others
- Does not understand the consequences of their behavior
- Agrees with everything, even if contradictory

# Impulsive

- Actions not well thought out
- May not be able to differentiate between appropriate and inappropriate behavior
- Some behaviors may be unknowingly self-endangering

# Clues to Developmental Disability

- Difficulty Reading or Writing
- Limited Vocabulary
- Speech Impairment
- Short Attention Span
- Difficulty Understanding or Answering Questions
- Difficulty With Abstract Concepts

# Behavior Clues

- Act inappropriately in social situations
- Be easily influenced by and eager to please others
- Be easily frustrated
- Have difficulty with the following tasks:

**** Giving accurate directions***

**** Making change***

**** Using the telephone & telephone book***

**** Telling time***

**** Reading***

**** Writing***

# Behavior Clues

- Say what he or she thinks others want to hear
- Have difficulty describing facts or details
- Not want their disability to be noticed by others
- React inappropriately either verbally or nonverbally to situations

# Strategies and Techniques

**Questions to ask:**

Where did you go to school?

- How old were you when you graduated?
- Did you take any special classes when you were in school?
- Has anyone ever told you you have a learning disability or are a slow learner?
- What time did you leave today to get here?

# Assessment and documentation of cognitive impairment

# Documenting Disability

## for Persons with Substance Use Disorders & Co-occurring Impairments:

## *A Guide for Clinicians*

**Prepared by**

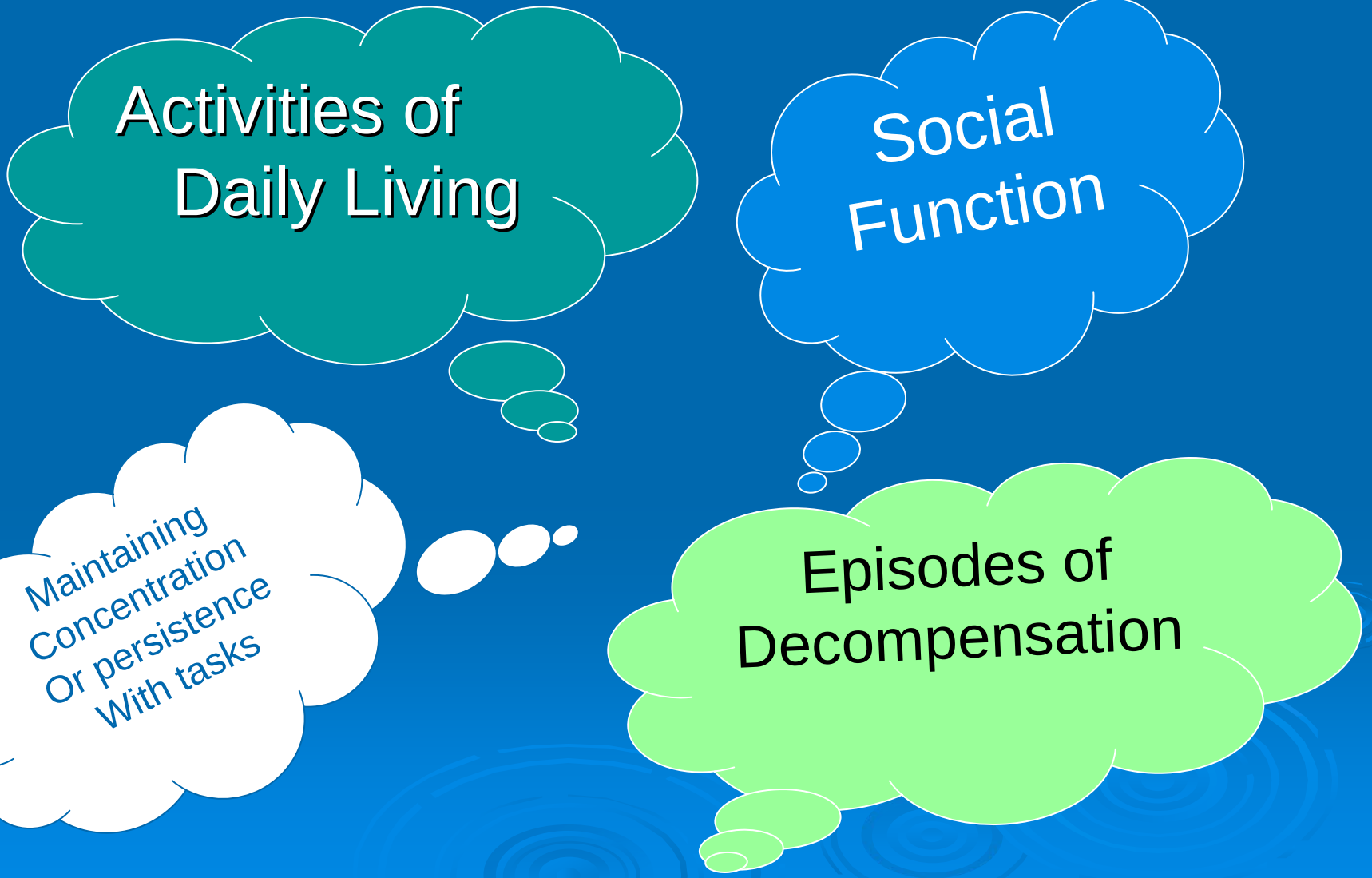
**Patricia Post, MPA**

**This project was funded through a Cooperative Agreement with the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.**

Disability Evaluation requires a new way of looking at your clients difficulties

When you think about Disability Evaluation, think about the client's ability, effectiveness and efficiency in managing the various aspects of his or her life

# The Four Realms of Function



# Key Questions

Can the client function independently?

Can the client function appropriately?

Can the client function effectively?

Can the client function on a sustained basis?

# Activities of Daily Living

- cleaning
- shopping
- cooking
- taking public transportation
- paying bills
- maintaining a residence
- grooming and hygiene
- using telephones and directories, and using a post office

From Social Security Bluebook

# Social Functioning

- getting along with others
- cooperative behaviors
- consideration for others
- awareness of others' feelings
- social maturity

From Social Security Bluebook

# Concentration and Persistence

The ability to sustain focused attention and concentration to permit the timely and appropriate completion of tasks commonly found in work settings

From Social Security Bluebook

# Decompensation

- Decompensation means temporary increases in symptoms or signs along with loss of adaptive functioning. To be disabling, decompensation episodes must last at least two weeks, and must occur
  - three times in one year, or
  - an average of once every 4 months

From Social Security Bluebook

# A functional analysis

# Task: Public Transportation

| | Yes | No |
|---|---|---|
| Can he do this by himself without help? | | |
| Does he end up calling attention to himself? | | |
| Does he end up getting where he wanted to go? | | |
| Can he do this over and over successfully? | | |

# Task: Public Transportation

| | Yes | No |
|---|---|---|
| Can he do this by himself without help? | X | |
| Does he end up calling attention to himself? | X | |
| Does he end up getting where he wanted to go? | X | |
| Can he do this over and over successfully? | | X |

# How impaired is he?

# Task: Public Transportation

| | None | Slight | Moderate | Marked | Severe |
|---|---|---|---|---|---|
| Can he do this by himself without help? | | X | | | |
| Does he end up calling attention to himself? | | | | X | |
| Does he end up getting where he wanted to go? | | X | | | |
| Can he do this over and over successfully? | | | | | X |

# The Disability Factors

- Independent Function
  - Can he do this by himself without help?
- Appropriate Function
  - Does he end up calling attention to himself?
- Effective Function
  - Does he end up getting where he wanted to go?
- Sustained Function
  - Can he do this over and over successfully?

# Eligibility – Step One
# Identify Symptoms

1. **Orientation**
2. **Memory**
3. **Learning ability**
4. **Hallucinations or delusions**
5. **Personality changes**
6. **Moods**
7. **Emotional lability**
8. **Impulse control**
9. **Loss of intellectual ability**

# Eligibility Step Two: Functional Impairment

Explain how the identified symptom results in:

- **Marked** restriction of activities of daily living, or
- **Marked** difficulties in maintaining social functioning, or
- **Marked** difficulties in maintaining concentration and/or persistence with tasks, or
- **Repeated** episodes of decompensation, each of extended duration

# Here's our formula

Explain how Wend's difficulty learning new information results in:

- **Marked** restriction of activities of daily living
- In other words, because he it's hard to learn new things, he can't manage public transportation by himself

Disability means that the person's condition results in significant problems with:

**Activities of Daily Living**
**Social Function**
**Concentration and Persistence, OR**
**Decompensation**

From the Social Security Bluebook

# Documentation Step One: Comprehensive Case History

- Educational history
- Early use of substance/alcohol
- Head injury
- Traumatic experiences
- History of suicide attempts
- Mental health
- Criminal justice involvement

# Educational History

- Behavior problems (fighting, aggression, truancy)
- Learning problems (failing grades, difficulty in specific subjects such as math or reading)
- Special education referrals
- Special schools attended

# Key Questions

- How many times were you sent to the principal's office?
- How often did you get into fights?
- What kinds of special testing did you do?
- What kinds of special classes did you attend?
- Were you the class clown?

# Why document educational experiences?

- Creates a case for long-standing
  - Learning disabilities
  - Behavior problems
  - Mental illness
  - Low intellectual function
- Reports are written often without any other medical or mental health records

# Sample documentation

When asked about his elementary school years, Mr. W stated, “I shut that off because it was such a nasty time.” He reports that it was difficult to pay attention and that he received “barely passing” grades. He states that he was evaluated by the school psychologist in third grade and underwent a battery of tests. Overall, he reports that he had a very difficult time in school. During middle school, Mr. W stated that he continued to find it difficult to pay attention and that once again he received “barely passing” grades. While he did graduate from high school, he reports that he received mostly C’s and D’s, had problems comprehending and retaining information and continued to have difficulty paying attention in class.

# Early use of substance/alcohol

- At what age did client first use street drugs or alcohol?
- What types of drugs?
- What quantity?
- How frequently?
- Why did the client use drugs/alcohol?

# Why document early substance/alcohol use?

- Creates case for disrupted development and education
- Creates case for long-standing use that can lead to more serious physiological dependence
- Implies a rough childhood that indicates a need for escape at an early age
- Might indicate early onset of serious mental illness

# Sample documentation

Mr. D reported that he became involved with illegal activity, drugs and drinking when he was approximately 10 years old.  He states that when he was 10, he was also sent to juvenile hall for stealing, fighting and drugs.

# Head injury

- Can cause
  - Behavior disturbances
  - Memory problems
  - Difficulty learning new information
  - Problems planning and organizing
  - Difficulty making decisions
  - Impulsive behavior
  - Aggressive behavior

# Key Questions

- How many car accidents have you had?
- How many times has someone hit you on the head?
- How many times have you passed out?
- How many bicycle accidents have you had?

# Why document head injury?

- Creates a case for neuropsychological impairment
  - Aphasia (language)
  - Apraxia (motor activities)
  - Agnosia (recognize objects)
  - Executive functioning disturbance:
    - Planning
    - Organizing
    - Sequencing
    - Abstracting


SOOPS

# Sample documentation

Mr. R states that he had experienced several head injuries. He stated that at approximately age 6, he flipped over the front handlebars on his bike. He stated that in 1977 he was involved in a motor vehicle accident when he fell asleep at the wheel. He reports that the car slid sideways off a windy road and that his head struck the windshield. He reported a work related head injury that occurred at an oil refinery. He states that his head got caught in-between moving equipment and a stationary pipe. He reports that the accident knocked his hard hat off his head and resulted in several stitches to his scalp. Mr. R also reports that he struck his head frequently while working at a car wash. Mr. R was unable to recall specific dates for these work related accidents.

# Documentation Step Two: Assessment

- Use comprehensive instruments that are well accepted, reliable and valid
- Neuropsychological evaluation tools

# Documenation Step Three: Additional Assessment

- Rorschach
- Thematic Apperception Test
- MMPI
- Millon™ Clinical Multiaxial Inventory-III
- Kennedy Axis V

# Documentation Step Four: Review of Records

- County Mental Health Activity Records
- Records from treating psychiatrists/physicians
- School records

# Documentation Step Five: Observations

- Ask for brief behavioral observation reports from:
  - Shelter staff
  - Outreach workers
  - Police officers
  - Hospital and emergency room staff
  - Treatment facility staff
  - Case managers

# Documentation Step Six: The Disability Evaluation Report

- General observations
- Present Illness
- Past History of Mental Disorder
- Family, Social, and Environmental History
- Current Mental Status
- Current Level of Functioning
- Current Medication
- Diagnosis

# Effectively managing cognitively impaired clients

# Strategies and Techniques

Maintain a supportive, professional, & respectful approach

- Ask questions to test retrieval of information just presented
- Use leveling – a physical position that results in having a comparable eye level
- Remove distractions in the environment
- Use simple language and short sentences
- Use open-ended questions
- ALLOW AMPLE TIME !!

# Effective Communication

- Get the person's attention before asking a question or giving information.
- Maintain the person's attention while communicating
- Be specific and concrete
- Use simple language
- Limit instructions based on ability.
- Use open-ended questions
- Make non-verbal communication agree with verbal.

# Communication

- Trying to communicate with a person who has cognitive impairment can be a challenge. Both understanding and being understood may be difficult.
- **Choose simple words and short sentences and use a gentle, calm tone of voice.**
- **Avoid talking to the person like a baby or talking about the person as if he or she weren't there.**
- **Minimize distractions and noise—such as the television or radio—to help the person focus on what you are saying.**

# Communication

- **Call the person by name, making sure you have his or her attention before speaking.**
- **Allow enough time for a response. Be careful not to interrupt.**
- **If the person is struggling to find a word or communicate a thought, gently try to provide the word he or she is looking for.**
- **Try to frame questions and instructions in a positive way.**

# The Basics of Good Communication

- Rules of communication between two cognitively intact persons (a 2-way street)
- When one person is cognitively impaired, there is often no longer an even exchange
- Setting the right tone

# Things to Think About When You Speak

- Make the setting free of distractions
- Gain attention, make eye contact, be aware of body language
- Provide orienting information

# Language that Works:
## *Techniques to enhance communication*

- Use short, simple sentences
- Use familiar and concrete words
- Break down tasks  into steps
- Avoid open-ended questions
- Help reduce choices

# When You Are Having Trouble Understanding

- Active listening
- Focus on word or phrase that may have meaning
- Respond to the emotional tone
- Try to stay calm and be patient
- Ask family members for clues

# When You Are Having Trouble Being Understood

- Allow enough time
- Give a visual demonstration
- Evaluate complexity of task
- Change the subject if necessary

# Things to Avoid

- Don’t argue
- Don’t give strict orders
- Don’t be condescending
- Don’t ask questions requiring detailed responses
- Don’t talk about people in front of them
- Don’t bother asking, “Do you remember?” in regard to recent events

# Errorless Learning – An effective way of learning skills

- **Do involve the person in doing and repeating.**
- **Do give information and cues freely.**
- **Do train the skill or information frequently and repeatedly.**
- **Do train the skill or information in the context where it will be used.**
- **Do encourage the use of reminders and compensations, such as lists, instructions, diaries, signs etc.**

# Errorless Learning

- **Don’t encourage guessing.**
- **Don’t use trial and error learning or expect the person to figure out how to do something alone.**
- **Don’t give the person a chance to make a mistake. If you are cuing and the person does not act or answer right away, give more of a cue until you get the right response.**

# Errorless Learning

- **Try to teach skills in the same setting and with the same materials that the person will be expected to use to carry out the activity. Show each step of the skill and have the person repeat it right away. Let the person get the "feel" of the activity, even by guiding their hands on the materials or tools when necessary.**

# Errorless Learning

Some information can be taught by turning it into an action, such as something the person says. Since the person learns slowly, it is important to choose information to teach that will be important for a while.

# Errorless Learning

For example, if it takes 30 repetitions to train for a simple piece of information, it is not practical to train the person to know the date since the process will need to be repeated every day. It is better to train the person to use a calendar-watch or a wall calendar (with the previous day crossed off).

# Errorless Learning

- Teacher (T): I am going to teach you your phone number. I will teach you to say “My phone number is 671-1369. ” You finish what I say. My phone number is 671-136 ni…..?
- Student (S): 9
- T: Good. My phone number is 671-136…?
- S: 9
- T: Good. My phone number is 671-13…?
- S: 69
- T: Good. My phone number is 671-1
- S: 369

# What do we want to accomplish today?

1. Reinforce what we know about cognitive impairment
2. Increase our understanding about the differences between cognitive impairment and other disorders
3. Increase our effectiveness in documenting impairment and dealing with disabled clients

# Is it worth the effort?

Clients, agencies and the community all benefit from identifying homeless men and women who have hidden disabilities.